



IRO REVIEWER REPORT – WC

DATE OF REVIEW: 01/20/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ACDF C3/4, C4/5 Allograft

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute:

- ACDF C3/4, C4/5 Allograft - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a who was injured at work on xx/xx/xx when tightening a strap on a load, he felt pain in his neck. He received conservative treatment which included physical therapy, medications, and injections. Multiple diagnostic testing has been perform. Records indicate current diagnoses include degenerative disc disease of the cervical spine, cervical radiculopathy, and herniated cervical disc. Due to continued symptomatology, the treating physician has recommended surgical intervention.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The cervical MRI of March 21, 2014, demonstrates minor degenerative changes, and a congenital fusion. After the injury, the employee sustained neck pain only. On, the injured employee stated, "The pain radiates to the left scapula, but denies radiating pain in the arms. He complains of a daily headache which is related to the neck pain. He complains of numbness in the right hand and tingling in the top of the left scapula. He denies weakness." Sensory, motor and reflex examination was normal. As a result, the designated doctor had an electrodiagnostic test performed April 17, 2014, which was performed by a physical therapist. The results of that test showed widespread changes that are not compatible with the physical examination or the claimant's symptoms. The injured employee underwent an epidural injection/nerve root block with no clinical response, confirming the absence of radiculopathy. The ODG only would authorize surgery if there was radiculopathy present. Not only are the claimant's symptoms non-radicular, there is no objective evidence of nerve root compression nor are there any physical findings that would be consistent with radiculopathy. Therefore, the previous denials are upheld; anterior cervical discectomy and fusion at C34 and C45 is not medically reasonable or necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**